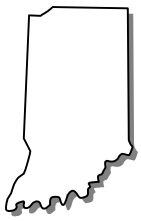
Medicare Buy–In Unit



INDIANA HEALTH COVERAGE PROGRAMS

Medicare Buy-In Procedures Manual

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Revision History

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Version 1.0	June 11, 1999	All	New document	Brandy Ludlum
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Table of Contents

Section 1: Introduction

Overview

Indiana Health Coverage Programs (IHCP) members who are entitled to receive Medicare benefits may have Medicare premiums paid by the IHCP. This is known as Medicare buy-in. Automated data exchanges between EDS and two federal agencies, the Social Security Administration (SSA) and the Health Care Finance Administration (HCFA) are conducted monthly to identify, update, resolve differences, and monitor new and ongoing Medicare buy-in cases. The County Divisions of Family and Children (CDFC) are responsible for initiating Medicare buy-in for eligible members. EDS coordinates Medicare buy-in resolution with SSA and HCFA.

Medicare buy-in is a program designed to allow participating states to pay Medicare premiums for dually-eligible (Medicare and IHCP) members, thereby ensuring enrollment in Medicare. Because Medicare is usually primary to IHCP, payment of Medicare premiums, coinsurance, and deductibles costs the Office of Medicaid Policy and Planning (OMPP) less than paying the entire cost of medical care for a member. In addition, the OMPP receives Federal Financial Participation (FFP) for premiums paid on behalf of members eligible as Qualified Medicare Beneficiaries (QMB), Qualified Disabled Working Individual (QDWI), Specified Low Income Medicare Beneficiaries (SLMB), and Money Grant recipients (Supplemental Security Income (SSI) and cash assistance from Aid to Families with Dependent Children (AFDC)). Two new aid categories for FFP include QI (Qualified Individual), QI-1, and QI-2.

Goals and Objectives

The primary goal of the Medicare buy-in operation is to ensure Medicare premiums are paid by the OMPP for eligible IHCP members. To meet this goal, the following objectives have been set:

- Ensure timeliness of data exchanges between HCFA, Indiana Family and Social Services Administration (IFSSA), and EDS
- Ensure Indiana*AIM* accurately applies updates to its Medicare buy-in data based on the following information:
  - Member Medicare data is received from ICES (data from the CDFC)
  - Accurate interaction with HCFA via the monthly data exchange

- Identify, coordinate, and resolve Medicare buy-in problems identified as a result of the data exchange
- Identify, coordinate, and follow through to receipt of recoupment of premiums paid inappropriately on behalf of IFSSA

Section 2: Organization and Staffing

Overview

The Third Party Liability (TPL) Unit manager oversees the operation and management of the unit. The TPL supervisor hires, trains, and monitors unit staff, and coordinates workflow and projects. The Medicare buy-in liaison coordinates the buy-in process and performs ongoing buy-in case management.

TPL Manager Responsibilities

- Directs Medicare buy-in staff in ensuring buy-in responsibilities are carried out timely and accurately
- Reviews and provides strategic direction of changes or enhancements to Medicare buy-in policy, procedures, edits, and reporting
- Oversees all staffing changes

TPL Supervisor Responsibilities

- Serves as supervisor for all buy-in functions
- Interviews and hires candidates for open positions
- Trains new and existing staff regarding procedures and procedural changes
- Performs ongoing reviews of Medicare buy-in policies, procedures, and reporting and makes recommendations to the TPL manager as appropriate
- Interacts with state, county, and other government agencies as related to Medicare buy-in
- Develops all desk-level procedures for use by the Medicare buy-in staff
- Directs Medicare buy-in staff in the production and distribution of required reports

Medicare Buy-In Liaison

- Directs Medicare buy-in related processing
- Responds to Medicare buy-in related inquiries, including HCFA, SSA, DFC, IFSSA, and other governmental inquiries

- Researches, monitors, and replies to related inquiries from the OMPP and county offices
- Takes responsibility for timely and accurate data exchanges with Medicare Parts A and B
- Distributes buy-in reports to IFSSA, as appropriate
- Reviews Medicare Parts A and B buy-in reports
- Performs primary ongoing Medicare buy-in case management, including coordination of problem resolution
- Coordinates recoupment of Medicare premiums
- Initiates changes with system requests (writing, testing, and follow-through)
- Generates written correspondence and reports related to Medicare buy-in data

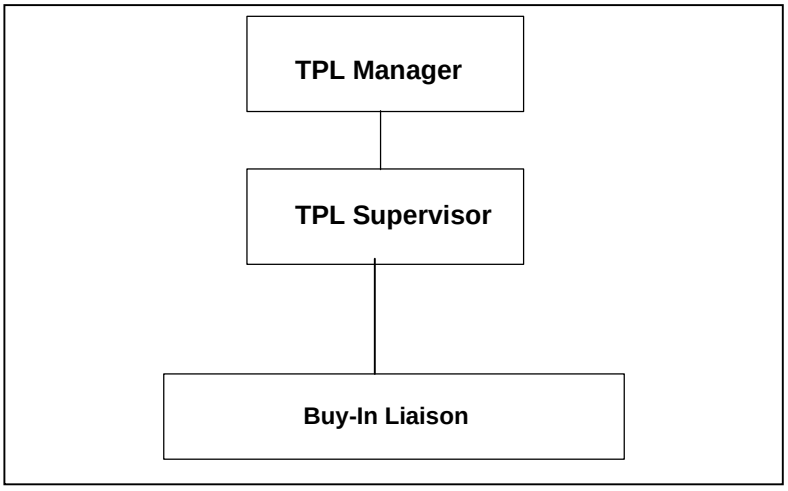

Figure 2.1 - Medicare Buy-In Organizational Chart

Section 3: Workflow Procedures

Overview

The primary purpose of the Medicare buy-in operation is to oversee the automated process of buy-in data exchange and maintenance, to perform the manual functions needed to resolve Medicare buy-in problems for premium payments, and to pursue reimbursement of Medicare premiums paid in error.

Buy-In Roles

Social Security Administration

The primary role of the SSA in Medicare buy-in is to determine which individuals are eligible for Medicare. This data is maintained in the SSA's computer *Master Beneficiary Record* and is obtained from the Beneficiary and Earnings Data Exchange (BENDEX) or Third Party Queries (TPQY) requests. Either form is a one-way data exchange from SSA to the OMPP, which provides basic information about beneficiaries, including eligibility for Social Security and Medicare.

In an **Accrete** state (1634 state), eligibility for Supplemental Security Income (SSI) automatically gives the OMPP appropriate Medicare buy-in eligibility information. The members are accreted to the OMPP's buy-in accounts by HCFA or by the OMPP. HCFA uses the BENDEX to auto-accrete.

Indiana is an **Alert** state. In an **Alert** state (209B state), the disability criteria for IHCP are more stringent than that for Medicare. The recipient eligible for SSI may or may not be eligible for IHCP.

Health Care Finance Administration

HCFA is a division of the United States Department of Health and Human Services. HCFA regulates and oversees the Medicare programs and IHCP. HCFA is the entity with whom the OMPP conducts the Medicare buy-in data exchange and to whom it makes payment of Medicare premiums. The Medicare buy-in data exchange is an interactive process. Indiana*AIM* sends requests to buy-in certain IHCP members to HCFA. HCFA responds to those requests by accreting the member to the OMPP buy-in rolls, or by reporting that

the person for whom the OMPP wants to pay the premium is not identifiable by HCFA.

HCFA maintains all Medicare data regarding eligibility, inquiries, claims processing, and entitlement updates in a system known as the Common Working File (CWF). This is to be replaced with the Medicare Transaction System (MTS). Medicare intermediaries and carriers may make inquiries of the CWF system. The HCFA Regional Office, Railroad Board, Office of Personnel Management, and SSA have indirect, limited CWF access.

Indiana Family and Social Services Administration

The IFSSA's role is to oversee and monitor the contractor responsible for administering Medicare buy-in. In addition, IFSSA's finance division receives the premium billing and generates payments to HCFA. Using data supplied by EDS, IFSSA is also responsible for HCFA reporting to obtain FFP reimbursement.

While IFSSA pays the Medicare premiums, the OMPP receives FFP, which is a percentage (approximately two-thirds) of the premiums for specific members. FFP is received for QMB, SLMB, QDWI, QI-1, QI-2, and all money grant (SSI or AFDC) member premiums.

ICES/County Caseworkers

As of January 1, 1994, all CDFCs implemented the Indiana Client Eligibility System (ICES). ICES allows the caseworker to enter all required eligibility data to determine IHCP eligibility. Once a member is determined to be eligible by ICES under a system-specified aid category, a member identification (RID) number is assigned to the member. The member is also assigned a case number. The case number applies to the entire household of eligible members, whereas, the RID number applies to the member within the case. The RID number is a unique number, assigned only once. Under no circumstances can Indiana*AIM* assign a RID number.

The CDFC caseworkers initiate the Medicare buy-in process by entering the buy-in data in ICES. ICES, in turn, interfaces with Indiana*AIM*. Indiana*AIM* determines the Medicare buy-in effective date once the eligibility information has been transmitted from ICES during the daily updates.

EDS

EDS maintains Indiana*AIM*. All data regarding IHCP member eligibility, Medicare eligibility as it relates to IHCP, and Medicare buy-in is available online. EDS coordinates the daily data exchange with ICES and the monthly data exchange with HCFA. EDS is responsible for resolving problems related to Medicare buy-in, including the investigation of duplicate records and conflicting data received from HCFA. EDS may enter specific data elements related to Medicare buy-in. All other data updates are coordinated with the CDFC, updated on ICES, and transmitted to EDS. EDS produces system-generated Medicare buy-in reports and researches potential Medicare buy-in cases identified through claims processing, CDFC inquiries, SSA inquiries, and so forth.

Tape Handling Procedures

On Thursday of the first full week of each month, HCFA sends the Part A and Part B Medicare buy-in billing data via Network Data Mover (NDM) directly to IFSSA. A paper billing for the total premium due is sent to State Accounts and Audits that processes the premium payment through Financial Management. The OMPP forwards the data electronically to EDS who runs the billing tapes to create paper reports and update Indiana*AIM*. (See *Buy-In Schedule* in *Section 8: Special Information*).

Approximately one week prior to the 25th day of each month, EDS Systems staff members schedule the premium jobs to run. Medicare buy-in staff members enter any transactions not performed systematically (for example, a change in HIB number). Indiana*AIM* creates the Premium 150 (Part B) and the Premium S15 (Part A). EDS Systems staff create FTP Transmit tapes and send them to IFSSA. IFSSA transmits the data to HCFA via NDM. The premium data must be received by HCFA by the 25th of the month to guarantee system update prior to the next month's billing.

Medicare Entitlement Eligibility

Medicare Part A

Medicare Part A, which primarily covers inpatient services, is offered at no charge. A member is eligible for free Part A (no premium payment) under the following conditions:

- The member has been disabled for at least 25 months, as determined by the SSA, with continuous IHCP coverage
- The member has been receiving Social Security benefits through the following programs:
  - SSI
  - Retirement Survivors Disability Benefits (RSDI) for members over 65
  - End Stage Renal Disease (ESRD)

The OMPP pays Medicare Part A premiums only for IHCP members who qualify as QMBs or QDWIs.

A member is eligible for Premium Part A under the following conditions:

- The member receives SSI only (no work history) *and* has turned age 65
- The member is a QDWI who lost premium-free HI (Hospital Insurance - Medicare Part A) solely because of work and is entitled to enroll in Part A under Chapter 1818A of the Social Security Act

A member may also be eligible for Premium Part A at a reduced premium if they, or a relative, under whom they can claim benefits, had some eligible quarters of work history, even though the member or the relative did not meet the minimum to qualify for free Part A.

Medicare Part B

Medicare Part B primarily covers medical expenses and professional fees. A Medicare recipient, who is eligible for Part A is also eligible for Medicare Part B. However, Part B premiums must be paid to receive benefits. Part B premiums are usually deducted from the beneficiary's monthly Social Security check. When beneficiaries qualify for Medicare buy-in, IHCP pays the premiums so that they are no longer deducted.

As with Part A, a member is eligible for paid Part B plus a penalty if the member did not pay for Part B when *first* eligible for IHCP benefits

> *Note: The OMPP is excluded from paying the additional penalty. Also, the penalty is not reinstated to the member after the OMPP has started buy-in.*

Who is Eligible for Medicare Buy-In?

The OMPP may buy-in the following individuals:

- People age 65 or over who have premium-free Medicare Part A
- All other people age 65 or over who are U.S. residents—either citizens or aliens lawfully admitted for permanent residence—who have resided in the U.S. continuously during the five years immediately preceding the month they apply for enrollment.
- People under age 65 who are eligible for premium-free HI because they have been entitled to monthly Social Security disability benefits under Title II or Railroad disability benefits for more than 24 months.
- People who are eligible for premium-free HI because the have ESRD.
- Specified low-income Medicare beneficiary (SLMB),QMB, QDWI, QI-1, QI-2 - not eligible for IHCP because of income level being slightly higher than allowed. (Medicare buy-in is mandatory for these individuals).

*A **QMB Only*** is eligible for IHCP payment of the Medicare Part B premium, coinsurance, and deductible. These members are identified in Indiana*AIM* as MA-L on the Recipient Eligibility window. There is no retroactive coverage for a QMB. A QMB income cannot exceed 100 percent of the federal poverty level, and resources cannot exceed twice the SSI limit.

*A **QMB Plus*** has the same income restrictions as the **QMB only**, but is eligible for full benefits for services provided by IHCP providers. This aid category is identified on the Dual Aid Eligibility window as MA-L

An ***SLMB*** is eligible for IHCP payment of the Medicare Part B premium. In Indiana*AIM*, this aid category is identified as MA-J. The allowable income level to qualify as an SLMB is slightly higher than as a QMB. An SLMB may be retroactively eligible up to three months prior to the month of application for Medicare buy-in. An SLMB may also be eligible for another aid category of assistance in addition to being an SLMB. An SLMB is not eligible for Part A Buy-In.

A ***QDWI,*** who is not otherwise eligible for IHCP, is entitled to Part A of Medicare when income is below 200 percent of the federal poverty level and resources do not exceed twice the SSI limit. Eligibility for IHCP benefits is limited to payment of Medicare Part A premiums as identified as MA-G in Indiana*AIM*.

A ***QI-1***, effective January 1, 1998, through December 31, 2002, is entitled to Part A of Medicare, with income above 120 percent, but less than 135 percent of the federal poverty level and resources not exceeding twice the SSI limit, and is not otherwise eligible for IHCP. Eligibility for IHCP benefits is limited to full payment of Medicare Part B premiums and is identified as MA-I in Indiana*AIM*. FFP equals the federal medical assistance percentage (FMAP) at 100 percent, but is annually capped. Entitlement of the member is limited by the availability of the capped allocation.

A ***QI-2***, effective January 1, 1998, through December 31, 2002, is entitled to Part A of Medicare, with income at least 135 percent, but not exceeding 175 percent of the federal poverty level and resources not exceeding twice the SSI limit, and is not otherwise eligible for IHCP. Entitlement is limited to partial payment of Medicare Part B premiums and is otherwise the same federal financial requirements as QI-1s. QI-2 is identified in Indiana*AIM* as MA-K.

Determination of Part A Buy-In Effective Date

QMB, aid category MA L

The OMPP premium liability begins with the month after the month in which the OMPP determines that an individual is a QMB. For example, if a QMB eligibility determination is made on August 15, the OMPP premium liability begins September 1. A QMB is ICES aid category MA L. The Medicare buy-in effective date and the date for MA L eligibility is the month following the month in which the QMB determination is made. QMB is never a retroactive determination.

QDWI, aid category MA G or MAGP

The effective date for Medicare Part A Buy-In for QDWI is the effective date of QDWI determination.

Determination of Part B Buy-In Effective Date

The effective date for Medicare Part B Buy-In accretion is determined by the money grant, QMB, SLMB, or QI-1 status of the member.

Money Grant Recipients*:* Recipients who receive all or *any portion* of their monthly income from any of the sources below are determined by ICES to be money grant **Yes** recipients:

- SSI—This includes certain individuals no longer eligible for SSI cash assistance due to increased resources, but retain their SSI recipient status under the provisions of section 1619 of the Social Security Act
- Aid to Families with Dependent Children (AFDC)

- Room and Board Assistance (RBA)

All other members are determined by ICES to be non-money grant members.

Money grant status is transmitted from ICES to Indiana*AIM*. The money grant status is found on the Recipient Base window in Indiana*AIM*.

Money grant status can be found on the Recipient Base window in the Money Grant field.

The Medicare buy-in effective date for money grant recipients is the latest of either the IHCP effective date, the Medicare effective date, or the effective date of the money grant.

Non-Money Grant Recipients:

Non-money grant recipients are those who receive either no income or income from sources *other than* those listed previously. These include the following:

- Retirement Survivors and Disability (RSDI)
- Veteran's benefits
- Railroad retiree benefits

1. *For new cases with IHCP*:

- The Medicare Part B Buy-In effective date for non-money grant, non-QMB, non-SLMB, non-QI recipients is the effective date of the member's IHCP eligibility, plus two months.
- The Medicare buy-in effective date for non-money grant, QMB recipients, is the effective date of MA L eligibility, which is the month following the month in which the member is determined eligible as QMB or two months after IHCP eligibility, whichever comes first.
- The Medicare buy-in effective date for non-money grant, SLMB members, is the effective date of SLMB (MA J) eligibility or two months after the IHCP eligibility, whichever comes first.

2. *For active (continuing) cases with IHCP*:

The Medicare buy-in effective date is the month in which Medicare eligibility begins, regardless of the money grant or QMB status. See Figure 3.1 for the Medicare Part B Buy-In effective date determination.

MEDICARE PART B BUY-IN EFFECTIVE DATE DETERMINATION

MONEY GRANT STATUS FOR THE BUY-IN EFFECTIVE DATE

MONEY GRANT:

A money grant recipient effective date is the date of Medicare entitlement, regardless of IHCP aid category.

NON-MONEY GRANT:

A non-money grant recipient does not receive SSI, RBA, or AFDC. The buy-in effective date is dependent on the Medicare entitlement date.

Aid category MAL or MAJ or MAI:

The buy-in effective date is dependent on the Medicare entitlement date. If the Medicare entitlement is prior to IHCP eligibility, the effective date becomes the IHCP effective date.

ACTIVE RECIPIENT:

Becomes Medicare eligible on:

- The month of the 65th birthday
- The month of Medicare entitlement

Not MA L or MA J or MAI NEW RECIPIENT:

The date on which CDFC determined IHCP eligibility *plus two months*

Figure 3.1 – Medicare Part B Buy-In Effective Date Determination

Understanding the Health Insurance Beneficiary Number

The Health Insurance Beneficiary (HIB) number is also referred to as the claim number of a Medicare Beneficiary. In this manual, it is referred to as the HIB number.

The HIB number is the Social Security number of the individual on whose earnings Social Security benefits are being paid. It is also the number on which Medicare entitlement has been established. The HIB number includes an alphanumeric suffix known as the Beneficiary Identification Code (BIC), which designates the type of benefits the individual receives, such as the wage earner's, spouse's, or child's benefits. See the table of BIC codes in the State *Buy-In Manual* in the *Special Information* section for a complete listing of BIC codes.

A railroad retiree receives retirement benefits based on a Railroad Retirement Board (RRB) claim number rather than a Social Security claim number. This number is either a six- or a nine-digit number with an alphabetic prefix. Because processing Medicare buy-in data is done through an electronic data processing system, it requires that the data be consistent in format. Each RRB claim number must be converted to a pseudo Social Security claim number format. Indiana*AIM* performs this conversion. (See the *HCFA Buy-In Manual*, located on *I:/BUYIN/HCFA*, for the conversion specifications)

Sources of Potential Recipient Buy-In Information

Listed in the following text are examples of resources for acquiring potential members to the Medicare buy-in program.

Caseworker

During the client interview and subsequent IHCP eligibility determination, the caseworker is responsible for gathering information concerning Medicare eligibility and the potential for Medicare buy-in. The caseworker enters the data in ICES on the AEFMC screen entitled **(MA) Medical Insurance Coverage**. One screen per carrier (one for Part A and one for Part B) is completed. The AEFMC screen is for entering Medicare and other TPL information. To prevent invalid data entry of HIB numbers, edit logic is incorporated into ICES making the benefit code carrier specific. Medicare Part B benefit can only be entered for carrier numbers 0000002 (regular Medicare Part B), 0008053 (Railroad Retirees Medicare Part B), and 11641 (United Mine Workers Medicare Part B). The Medicare Part A benefit can only be entered for carrier number 0006002. EDS has access to ICES and the AEFMC screen for viewing only. Currently, Indiana*AIM* can enter the Medicare buy-in effective date, since this is no longer determined by the caseworker.

The AEFMC data includes the following:

- Policyholder name
- Policyholder SSN
- Carrier number
- Carrier name
- Carrier address
- Policy type

- Policy/HIB number
- Group number (not used for Medicare)
- Benefit type (benefit/coverage code)
- Begin date
- End date
- Qualified disabled worker
- QDWI Part A end date
- Part B Premium
- Part A begin date
- Policyholder's relationship to insured recipient

ICES Medical Insurance Screen

Figure 3.2 shows how the AEFMC screen appears on ICES.

```
AEFMC                          (MA) MEDICAL INSURANCE COVERAGE                99/99/99  99:99

COUNTY:   99 CASE: 9999999999   WORKER: XXX999

LAST ACTIVITY DATE: 99/99/99       STATUS: PENDING

DC NBR-------------------------POLICY HOLDER----------------------------------   SSN
___ 99 XXXXXXXXXX  XXXXXXXXXXX XX                  999999999

CARRIER NUMBER       CARRIER NAME                      CARRIER ADDRESS
 9999999999     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                 _____________________________
                                                                 _____________________________
                                                                 _____ __ _____
POLICY/HIB NBR      GROUP NUMBER     BEN TYPE    BEGIN DATE    END DATE  VR   FAMILY COV
99999999999999     9999999999      XXXXXXXXXX   99/99/99       99/99/99  __      X
QUAL DIS WORKER? X  PART A: END _________ PREMIUM PART A:  BEG: _____________________  VR:___ ---
MEDICARE PART B BUY-IN EFFECTIVE DATE: _____________   VR: ___
-------------------------------------------------------INSURED ------------------------------------------------------
 DC NBR OCCUR DATE REL DC NBR OCCUR DATE REL  DC NBR OCCUR DATE  REL
 ___ 99 _____________ XXX  ___ 99 _____________ XXX  ___ 99 _____________  XXX
 ___ __ _____________ ___  ___ __ _____________ ___  ___ __ _____________  ___
-------------------------------------------------------INDIVIDUALS----------------------------------------------------
1 XXXXX X          2 XXXXX X




NEXT TRAN: _____________ PARMS: ____________________________________________________
```

Figure 3.2 – AEFMC Screen

The AEFMC screen on ICES shows member expenses including the Medicare premium amount. The Medicare premium payment field

appears **MB** beside the dollar amount if the OMPP is paying the premiums. If the Medicare premium is being deducted from the member's Social Security check then **MS** appears beside the dollar amount.

The data is transmitted daily from ICES to Indiana*AIM* and is found on the Third Party Liability Detail Resource window, and in the case of Medicare, on the Medicare Coverage window.

The CDFC may have information about a member's approval for Medicare either from a Medicare card or a Third Party Query (TPQY). If so, the CDFC may notify EDS of a potential Medicare buy-in, or they may discuss any problems with a Medicare buy-in solution.

Social Security Administration

The OMPP may send requests to the Social Security Administration (SSA) for Social Security information regarding IHCP members. This beneficiary data is referred to as **BENDATA**. The SSA processes the requests then creates and sends the BENDEX records to the OMPP. ICES maintains the BENDEX records on a screen (DEBN) that is used by the Medicare buy-in analyst.

The following references are sources of Medicare information provided by the SSA:

BENDEX

BENDEX is the monthly data from the SSA that is produced from the BENDATA sent by the OMPP. The BENDEX data updates the beneficiary Social Security and Medicare information on the DEBN screen on ICES. BENDEX does not interact with the AEFMC screen. A complete list of BENDEX data is included in the *Section 8: Special Information*. See the *BENDEX Manual, Section 10801.220* for the fields and descriptions.

TPQY

The TPQY also provides data regarding Medicare beneficiaries eligible for buy-in. Caseworkers and Medicare buy-in staff can request information from the local SSA office. The information is current as of the date it is printed. The TPQY data is information contained in the Master Beneficiary Record (MBR). The data includes information shown in Table 3.1.

Table 3.1 – TPQY Data

Master Beneficiary Record Information	
SSN	Name
HIB	Sex
Date of birth	Entitlement date
Payment status code	Net monthly benefit
Benefit history	
Part B entitlement date Premium amount Buy-In start date	Part A entitlement date Premium amount Buy-In start date
Citizen/alien code	Disability start date
Residence address	Mailing address
Payment status code	Payment history of net benefits paid

SDX

The State Data Exchange (SDX) is conducted monthly with the SSA and contains a record of every SSI recipient in Indiana. The data includes the information shown in Table 3.2.

Table 3.2 – SDX Data

Name,	SSN,
HIB,	Date of Birth,
Date of SSI eligibility,	Date of Death,
Payment status,	Living arrangement,
Marital status, and	Various income data.

This data is also kept in ICES.

Member

The member is the primary source of the data needed for buy-in. Prior to buy-in Medicare premiums, the member may be paid by deduction from the member's Social Security check each month, or by out-of-pocket payment directly to HCFA. The member may not have applied for Medicare or may have rejected Medicare coverage by refusing to pay the premiums. Once informed that the OMPP will pay Medicare premiums, the member should notify the caseworker if any of the following occurs:

- Buy-In does not occur when expected

- The member does not receive the refund for premiums already paid by him or her
- Buy-In stops while the member is still eligible.

Congressional Inquiry

Occasionally, a member contacts a congressional representative concerning problems with buy-in. When this occurs, the congressman's office may contact EDS, the OMPP, Social Security, or the caseworker to learn why there is a problem, and if appropriate, when it will be corrected. This allows the caseworker and Indiana*AIM* to update any discrepancies in the Medicare buy-in resolution files.

Claims

When a crossover claim is processed and paid in Indiana*AIM*, the system searches the Recipient Table to ensure the member has Medicare coverage. If not, the data is reported on the Possible Medicare Eligibility report (*BUY-3001-M*). (See the *Section 5:Reports*). Medicare buy-in staff follow up on these potential cases.

Health Care Financing Administration

HCFA is the Bureau of Program Operations (BPO), Office of Customer Communications (OCC), Entitlement and Premium Billing (EPB). HCFA has overall responsibility for the administration of the Medicare buy-in provisions of the Social Security Act.

HCFA is the agency with which EDS coordinates the monthly Medicare buy-in premium billing tape exchange. The data received corrects problems with Medicare buy-in.

HCFA informs the OMPP of potential Medicare buy-in recipients and transfers recipients from other states' Medicare buy-in accounts to Indiana accounts. HCFA also contacts the OMPP when Medicare buy-in problems occur that are not being solved through the data exchange.

The following are reference sources of Medicare information provided by HCFA:

BEST

The data on the Health Insurance Beneficiary State Tape (BEST) includes the following:

- Beneficiary's name
- Beneficiary SSN (his or her own SSN)
- BIC
- Previous BIC
- Date of Birth
- State buy-in indicator
- Sex code
- Railroad indicator
- Address
- Member SSN

History Tape (TPFAB S15)

Indiana is does not currently receive this history tape.

History Tape (TPFAB S15/150);

The Medicare Part B Buy-In History Tape is run by the OMPP request only. It may be requested two times per year and is available through the Network Data Mover (NDM).

EDB File

The Eligibility Date Base (HI Master) has already been detailed. EDS must request an EDB printout from the Social Security Administration, request data from the EDB by telephone, or refer to the DEBN on ICES.

Railroad Board

The Railroad Board provides data concerning railroad retirees, disabled railroad employees, and their dependents that are eligible for Medicare through the Railroad Board. The Railroad Board pays the premiums if IHCP does not. Information about railroad retirees may only be obtained through the billing reports from HCFA or by calling the Railroad Board.

Indiana*AIM* Premium S15/150 Buy-In

Indiana*AIM* is designed to carry out an interactive data exchanges with HCFA via the monthly data exchange process. This occurs through

the NDM. When IFSSA receives the monthly billing transactions via NDM, an electronic transmission is created and sent to EDS. Once entered in Indiana*AIM*, the data is reviewed, and processed or corrected. Indiana*AIM* creates the Premium S15 and 150 electronic transmissions, and sends them to IFSSA, which, in turn, transmits the data to HCFA via NDM.

The Premium S15 and 150 tapes are created in Indiana*AIM* using the following member eligibility data:

- Medicare additions, terminations, and updates
- Updates received from ICES
- Transactions received from HCFA
- Medicare additions, terminations, and updates manually input into Indiana*AIM*.

The changes on the recipient base include new IHCP eligibility, termination of IHCP eligibility, name changes, date of birth corrections, sex corrections, RID number changes, and so forth.

Premium S15 (Part A Sending Tape BIA-1002-M)

The Premium S15 Sending Tape contains all of the Medicare Part A accretions, deletions, and information change requests sent by the OMPP each month. QMB and QDWI eligible members are reported. After the monthly Part A Buy-In Billing Tape is processed by Indiana*AIM*, the system-generated updates, manual updates, accretions, deletions, and changes are sent to HCFA on the Premium S15 Sending Tape. HCFA uses this data either to update records or to reject the transactions for the following month's Medicare Part A Buy-In Billing Tape to IFSSA. The BIA-1002-M is created reflecting the Premium S15 data. (See the *Section 5:Reports* for more information).

Premium 150 (Part B Sending Tape BIB-2002-M)

The Premium 150 contains all of the Medicare Part B accretions, deletions, and information change requests sent by the OMPP each month. (See the file layout in Table 3.1). After the monthly Medicare Part B Buy-In Billing Tape is processed by Indiana*AIM*, the system-generated updates, manual updates, accretions, deletions, and changes are sent to HCFA on the Premium 150 Sending Tape. HCFA uses this data either to update records, or to reject the transactions for the following month's Medicare Part B Buy-In Billing Tape to IFSSA. A paper report is created reflecting the Premium 150 data. (See *Section 5: Reports* for more information).

Part A and Part B Buy-In Output: State Initiated Accretion, Deletion, and Change Record

The following table illustrates the format used to transmit information to HCFA.

Table 3.3 - Record Format

Field	Positions	Field Name	# of Positions
1	1-12	Medicare Claim Number	12
2	13-24	Surname	12
3	25-31	First Name	7
4	32	Middle Initial	1
5	33	Sex Code	1
6	34-39	Date of Birth	6
7	40-46	Blank	7
8	47-49	Agency Code	3
9	50	Blank	1
10	51-59	Blank	9
11	60-61	Transaction Code	2
12	62-63	Blank	2
13	64-67	Transaction Date	4
14	68-79	State Welfare Identification Number	12
15	80	Record Mark	1

Premium S15/Premium 150 Sending Transaction Codes

Additions, deletions, updates, and changes in Indiana*AIM* that affect Medicare buy-in are communicated to HCFA by specific **sending** transaction codes on the Premium 150 and Premium S15. The Medicare buy-in transaction codes provide a definitive means of communication between HCFA and the OMPP. The codes are two to four digits. Transaction codes 61, 62, 63, and 84 are accretion codes. Transaction codes 50, 51, and 53 are deletion codes. A simultaneous accretion and deletion sent in the same month are codes 75 and 76 for a closed period of Medicare buy-in coverage. When the OMPP sends a change on information, a code 99 is used.

Some codes have specific rules. For example, code 51 is a general termination of Medicare buy-in. Under Part B, the OMPP may only recoup up to two months of premium payments made after the deletion should have occurred. (See *Commissioner's Decision in the next paragraph)*. Under Part A, the OMPP may only receive credit for up

to one month of premium payments. However, if buy-in ends due to the death of the beneficiary, the entire premium paid for each month after the date of death may be credited to the OMPP.

> *Note: A complete explanation of the transaction codes is included in the Special Information section in the State Buy-In Manual, which can be found in the Section 8: Special Information. See Table 3.5 or 3.6.*

Commissioner's Decision

When the Medicare Part B Buy-In program was implemented in July 1966, states were allowed to delete members on a retroactively and could annul a member's entire buy-in coverage period if the OMPP determined that the member should not have been enrolled in the buy-in program. When the OMPP deleted the member, the entire amount of premiums paid was credited to the OMPP. As a result, the member was held responsible for the entire premium amount. In effect, a hardship was placed on the member when the SSA withheld money from the member's Social Security check to recover the premiums that, in many cases, were substantial.

In 1972, the Commissioner of the Social Security Administration issued a regulation to prevent this hardship. The regulation, commonly referred to as the *Commissioner's Decision*, limits the retroactivity of the deletion date to two months from the month in which the Medicare buy-in system received the deletion request. For example, if the state submitted a deletion action to HCFA in August 1982, the deletion date could not be earlier than June 1982. If the state entered a date earlier than June 1982, the Medicare buy-in system automatically adjusted the deletion date to conform to the two-month retroactive deletion rule. The deletion date would be processed with an effective date of June 1982. The Commissioner's Decision applies only to code 51 deletion requests that are received by HCFA on a timely basis. Deletions due to death may still be adjusted back to the date of death.

Letters

Other output includes various letters to obtain Medicare buy-in information or to respond to Medicare buy-in inquiries. The following are examples of correspondence sent by EDS (See *Section 6: Forms and Letters* for more information.):

- Letters sent to HCFA—EDS may contact Health Care Finance Administration, at the following address:
  - Health Care Financing Administration
    Div. Third Party Billing

P.O. Box 11977
Baltimore, MD 21207-0977

- Notification to the caseworker—When EDS identifies a member who should be enrolled in Medicare, but who has not applied, notification is sent through ICES asking the caseworker to send *Form 1610* to the SSA for Medicare buy-in purposes. Buy-In staff and caseworkers may also call the SSA office directly. Some SSA staff now use ICES, so the caseworker can send e-mail as well.
- Letters to the Social Security Administration—Medicare buy-in staff may request a TPQY, a query response from SSA, via regular mail. See Figure 6.6 for an example.
- Letters to the Railroad Board—EDS may request data on Railroad Board Medicare beneficiaries. However, most queries are handled by telephone calls to the Railroad Board.

Forms

The forms used for buy-in processing are:

- 1610 Form—This form, produced by SSA, is used by the CDFC to request that SSA process the member's Medicare application for buy-in. This form is only used for SSI recipients, age 65 or older, who have never applied for Medicare. The caseworker sends the form to the county's local Social Security office. Refer to the *HCFA State Buy-In Manual* for a copy of the SSA Form 1610.

Indiana*AIM* Buy-In Output Interface with HCFA and SSA

Federal Systems Involved in Medicare Buy-In Process

HCFA

HCFA uses two files when processing buy-in data:

- The Eligibility Data Master (EDB), formerly referred to as the HI/SMI Master File. The EDB contains all Medicare records, including denied enrollment.
- Third Party Master (TPM) monitors and controls buy-in.

SSA

SSA uses two files that coordinate with HCFA and the states to maintain Medicare eligibility information:

- The MBR file contains all Social Security records including Medicare data. The TPQY is produced from the MBR.

- The Supplemental Security Income Record (SSIR). This is the file of all SSI records. The SDX is produced from the SSIR.

Updating the Third Party Master File

The Third Party Master File receives data and is updated from various sources. Indiana sends updated information to the Third Party Master File by means of the Premium (sending) data sent. The Third Party Master File sends information back to Indiana by means of the Billing (receiving) data received by Indiana. Other agencies and systems also interface with the Third Party Master File (for example, HCFA, EDB, and SSA). This data exchange process is as follows:

The premium data is sent to the TPM. The EDB updates the TPM, which is also updated by SSA, and produces the BEST records. SSA updates the EDB and produces the SDX. The TPM updates the MBR that produces the BENDEX. The TPQY is produced from the MBR). Finally, the TPM produces the billing data, which is sent to Indiana. The flow chart in Figure 3.3 shows the data flow.

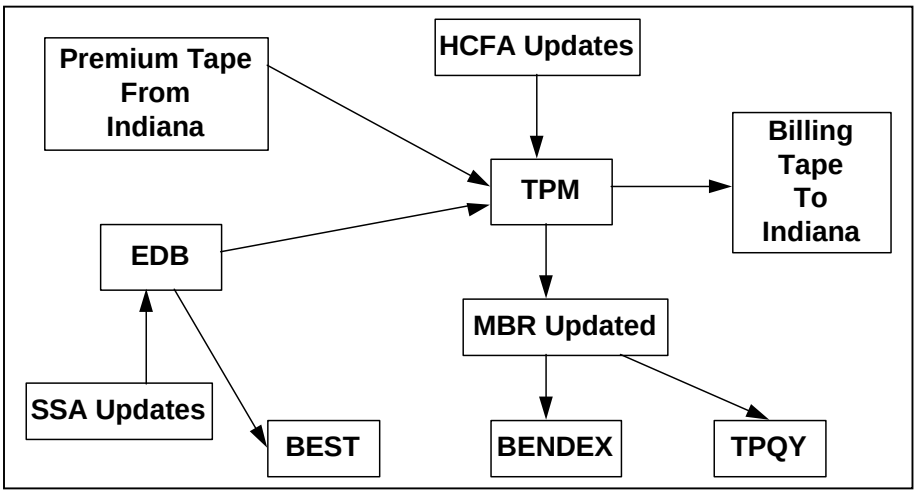

Figure 3.3 - Workflow Graphic - File Input/Output

Buy-In Output from HCFA

Output to Indiana

HCFA sends Indiana, via NDM, Medicare Part A and Medicare Part B billing records.

Billing Information

The billing (also referred to as the receiving) information includes the HIB, name, sex, birth date, agency code, sub-code, billing date, transaction code, effective date of the transaction, RID number, and the premium amount.

Table 3.4 – Billing File: Record of SSI Accretion/Deletion Alert Action For Alert States (Record Format:)

Field	Position	Field Name	# of Positions
1	1-12	Medicare Claim Number	12
2	13-24	Surname	12
3	25-31	First Name	7
4	32	Middle Initial	1
5	33	Sex Code	1
6	34-39	Date of Birth	6
7	40-44	Blank	5
8	45	Living Arrangement Code	1
9	46	SSI Status Code	1
10	47-49	Agency Code	3
11	50	Buy-In Eligibility Code	1
12	51-55	Blank	5
13	56-59	Date of Attainment of Age 65 or Entitlement to Hospital Insurance Benefits	4
14	60-61	Transaction Code	2
15	62-63	Blank	2
16	64-67	Transaction Date	4
17	68-79	Social Security Number and County Residence Code or State Welfare Identification Number	12
18	80	Blank	1
19	81-89	Zip Code	9
20	90	Blank	1
21	91-96	Zero Filled	6
22	97-99	Blank	3
23	100	Record Mark	1

Records Received from HCFA for Buy-In Activity

For the billing file to systematically update a member's Medicare buy-in information in Indiana*AIM*, the beneficiary's HIB, date of birth, and sex must match. If these elements match, the member's accretion, deletion, change information, and so forth is updated on the Billing window(s) in Indiana*AIM*. If any one element (HIB, date of birth, sex, and/or dates for buy-in) does not match, the data is sent to the Part B

Billing or Part A Billing window with error codes for resolution. This is also shown on the Part A *BIA 1004-M* and Part B *BIB 2004-M* (The Buy-In Exception Error Report by Transaction Codes).

Other records, such as transaction codes 1165, 1167, and 2161 are sent to the Buy-In Exception Error Reports for research.

HCFA also sends notices to IFSSA/EDS stating that an individual is receiving SSI but HCFA does not have information as to whether the individual is receiving IHCP. The case is investigated for potential buy-in. In some situations, HCFA may have already begun billing for an individual who is not eligible for buy-in (for example, not eligible for IHCP, QMB, QDWI, or SLMB). HCFA also notifies Indiana when SSI is stopped (code 87).

Deletion of buy-in coverage occurs due to death, end of IHCP eligibility, another state begins to pay the premiums, Medicare coverage ends, and other special situations.

HCFA also sends adjustments (credits, debits, effective dates, and so forth) to previously submitted data. These are 42bb, 42XX, 43XX, 1125, 1128, and 1728 transaction codes.

Public Welfare Accretion

A Public Welfare (PW) accretion appears as a transaction code of 1167. These transactions result from Social Security acknowledging that an individual has filed an application for Medicare and appears to be eligible for IHCP. Therefore, the individual is accreted by HCFA. The PW procedure establishes Part B Medicare for the individual via buy-in without any premiums being deducted from the individual's check for any period for which the State should be paying the premium.

In Indiana, EDS verifies whether the individual is an eligible IHCP recipient. If so, the accretion is accepted. If not, the State has four months following the 1167 notification to request an annulment and subsequent premium refunds of the buy-in action.

Output to SSA MBR

When the State buys-in a beneficiary, HCFA sends the data to the MBR for SSA check adjustment. The MBR sends data to HCFA when a recipient begins receiving SSI. The MBR also updates the Medicare Common Working File (CWF).

Notices Sent By SSA to Recipient

The SSA notifies the beneficiary when State buy-in begins or ends, usually about one week before his or her Social Security check is issued and sent. The IHCP is not responsible for recipient notification of buy-in.

Obtaining Premium Refunds from HCFA

Indiana may have paid Medicare premiums in error if IFSSA/EDS is notified of a situation that indicates the following:

- The individual is deceased.
- Indiana was paying for duplicate coverage on the same individual.
- The individual has moved to another state.
- Any other situation where premiums were paid for an ineligible individual for Medicare buy-in

When a caseworker enters a date of death or a termination of IHCP eligibility on the recipient's ICES record, Indiana*AIM* system-generates a deletion transaction to the Premium table that is sent to HCFA on the Premium S15/Prem 150 Sending tape. In other situations (those that are not due to a caseworker entering an end eligibility date on ICES) where IHCP is paying premiums in error, a deletion code is entered manually by EDS on the appropriate Premium window. In both situations, the data is sent to HCFA on the Premium tape. If the next month's billing does not show that HCFA deleted the recipient's buy-in, a request for reimbursement must be initiated by EDS. This is done by sending the memorandum, *Request for Premium Reimbursement*, (Figure 6.1) to the following address:

Health Care Finance Administration
HCFA, BPO, TPL
P.O. Box 11977
Baltimore, Maryland 21207-0977

The adjustment usually takes two to three months, but could take up to a year or more. The Buy-In Billing window or Buy-In Billing report should be researched each month to ensure the appropriate transaction has occurred and the premium adjustment has been made.

Working Buy-In Cases

When Does Buy-In Become a Case?

After the billing tape is run against Indiana*AIM*, two reports are produced that inform Indiana of the status of all buy-in recipients. These reports are the following:

- Buy-In Part A Billing (BIA-1001-M)
- Buy-In Part B Billing (BIB-2001-M).

In addition, error reports are produced that identify the transaction codes indicating problems with the acceptance of a buy-in transaction. They include the following:

- Buy-In Part A Exception Error by HIB (*BIA-1003-M*)
- Buy-In Part A Exception Error by Transaction Code (*BIA-1004-M*)
- Buy-In Part B Exception Error by HIB (*BIB-2003-M*)
- Buy-In Part B Exception Error by Transaction Code and (*BIB-2004-M*)

Other reports are used either for research or to identify other buy-in situations:

- Buy-In Part A Recipients without QMB Also or QMB Only (*BIA-1005-M*)
- Buy-In Part A Pending Transactions Awaiting Three Months Reply (*BIA-1006-M*)
- Buy-In Part A Recipients - Qualified Disabled Working Individuals (*BIA-1008-M*)
- Buy-In Part B Specified Low Income Medicare Beneficiaries (*BIB-2005-M*)
- Buy-In Part B Pending Transactions Awaiting Three Months Reply (*BIB-2006-M*)
- Possible Eligibles (*BUY-3001-M*)
- Attempted HIB Updates to Already Buy-In Recipients (*BUY-3002-M*)

The Mismatch window contains the members who have not matched HCFA files based on date of birth, HIB number, and/or sex. The problem must be tracked each month until the change is made and accepted by HCFA or Indiana*AIM*. Examples of potential problems

requiring investigation and follow-up are the following transaction codes:

Table 3.5 - Transaction Codes

Code	Description
1125	An adjustment was made to the accretion effective date
1128	An adjustment was made to the accretion effective date
1165	An accretion was processed on the TPM. EDS must verify whether or not it is an appropriate accretion.
1167	An accretion was processed on the TPM. EDS must verify whether the individual is an eligible IHCP recipient.
15bb	The individual was deleted as ineligible for Medicare per SSA records.
16bb	The individual is deceased per SSA records and was deleted.
1728	Another state requested buy-in of the individual.
18XX	No Medicare entitlement for this individual
19XX	The individual's application for Medicare was denied.
20XX	A submitted deletion was rejected for various reasons.
21XX	The submitted accretion did not match the MBR nor the EDB (HI Master).
22XX	The submitted accretion did not match the EDB but does match the MBR.
24XX	The submitted action was rejected due to an invalid effective date.
25XX	The submitted accretion or deletion was rejected as a duplicate.
27XX	The submitted accretion or deletion was rejected due to an invalid code.
28XX	The submitted accretion or deletion was rejected as simultaneous to another period already established on the TPM.
29XX	The submitted accretion or accretion or deletion was rejected due to a death deletion on the TPM.
30XX	The effective date of the submitted accretion requires adjustment to a later date.
31XX	The submitted action cannot be processed in the month submitted.
32XX	The submitted action cannot be processed as the requested coverage is prior to existing coverage on the TPM.
33XX	The submitted accretion was rejected as the individual is on the TPM as a code 91 for another state.
34XX	The submitted deletion was rejected as the individual is on the TPM as a code 91 for another state.
3662	The submitted accretion was rejected as not a match on the EDB or MBR.

Researching the Case

The first step is identification of the problem by researching the reports named in Table 3.5. Next, the specific transaction is reviewed to determine if the problem is due to a data entry error in ICES or in Indiana*AIM*. If, after research, there appears to be a disagreement between the data from the county and SSA/HCFA records, the decision, generally, is to accept Social Security records as correct unless there is evidence to suggest SSA's records are incorrect.

To correct the error, a copy of the error transaction report is needed (all 2161s, all 1167s, all 1728s, and so forth) along with the SSA BENDEX (DEBN) for cases compiled and researched. All efforts to research the problem are indicated on the individual SSA BENDEX (DEBN) and kept for reference. Each month is kept separately under the error code within the files sustained by the buy-in analyst. All offices contacted and what measures were taken to correct the buy-in are recorded for future references. Each problem is unique and must be reviewed as such. The problem could involve an invalid HIB or an incorrect date of birth or death that must be researched. If it is an 1167 (PW accretion), IHCP eligibility must be confirmed. If the recipient is not eligible for IHCP, the procedure stated in the State *Buy-In Manual* (Chapter II, sec. 263 and 266) for PW accretes must be followed.

If the problem appears to be a linking error between ICES and Indiana*AIM*, the problem resolution should be coordinated with OMPP.

Checking Resources

To obtain the data needed to enter a correction into the Eligibility and/or Premium Windows, any or all of the following resources may be researched:

- *The Billing Tape Report*—Is the recipient already accreted, deleted, and so forth?
- *The Premium Tape Report*—Was the accretion, deletion, or change ever sent?
- *The Caseworker*—If the recipient is over age 65 or has been disabled more than 25 months and is not receiving Medicare benefits already, the caseworker should be contacted to initiate Medicare entitlement via *Form 1610*. The caseworker may have other information concerning the recipient. Any changes to the recipient eligibility data should be coordinated through the caseworker and the corrections made in ICES.

- *DEBN and other ICES screens*—Access available in 1997
- *EDB*—Printout requested from SSA
- TPFAB Buy-In History—Twice a year on request

Resolving the Case

If the buy-in error involves an incorrect recipient name, date of birth, or sex code in Indiana*AIM*, the county caseworker should be contacted to correct the data on ICES. If the error is a date of death, ICES must send the corrected data to Indiana*AIM* through the daily interface. If the SSA/HCFA data appears to be incorrect, EDS contacts the county. The county contacts the recipient and/or must correct the error with SSA. Once corrected, the information may be changed in ICES.

If the error requires sending a transaction on the Premium S15/Premium 150, the appropriate transaction code is sent by entering the data on the Premium window. The following are the sending transaction codes some of which are automated in Indiana*AIM*:

Table 3.6 - Sending Transaction Codes

Code	Description
50	To annul or terminate Buy-In Part B coverage for txn 1165 only
51	To delete an individual
53	To delete an individual due to death
61	To accrete an individual to buy-in
62	To accrete an individual formerly rejected by the TPM (2161-Part B) as not matched on the EDB
63	To identify accretions being used for State analysis (Part B)
75	To accrete an individual - Used with a 76 as a simultaneous accretion or deletion action to establish a closed period of coverage *
76	To delete an individual - Used with a 75 as a simultaneous accretion or deletion action to establish a closed period of coverage *
84	To accrete an individual following receipt of a code 86 SSI Alert record (Part B)
99	To correct the sex code, or eligibility code, or to add or correct a RID Number in the HCFA record

**Note: A 75 (accretion) and 76 (deletion) combination can only be used in the same month. A 61 (accretion) and 51 (deletion) will not be accepted by HCFA in the same month.*

The following month's billing is reviewed to ensure the transaction was accepted by HCFA. If the transaction was not accepted by HCFA then further investigation and additional action may be required.

Section 4: Windows

> *Note: The windows referred to throughout this manual are documented in the Teleprocessing User Guide. Please refer to the appropriate Teleprocessing User Guide for additional information on screen access, edits, and functionality.*

The following information on windows is being provided to assist when researching Medicare buy-in cases online.

The recipient windows provide recipient information needed for the accurate processing of claims. In addition, all Medicare data including buy-in is maintained on the recipient windows. Therefore, the data may be used to research buy-in problems. Following is a list of the recipient windows applicable to buy-in, including how to access each window and the data contained on the window from the recipient tables.

Recipient Search

After logging in to Indiana*AIM* and selecting **Recipient**, the Recipient Search window has the following options to be data filled:

- RID number
- Previous identification number
- Medicare identification number
- Case number
- Social Security number
- Birth date
- Last name
- First name

By pressing **Select**, the requested Recipient Base window appears.

Recipient Base

After the system searches for the recipient based on the data entered on the Search window, the Recipient Base window appears. The data includes the following:

- RID number

- Marital status
  - S= Single
  - T= Separated
  - D= Divorced
  - W= Widowed
  - X= Unknown
  - M= Married
- Ward code
  - Y= Yes
  - N= No
  - CHINS
  - Court order
  - Parent term
- Ward county
- Age
- Money grant
  - Y= Yes
  - N= No
- Name
- Address
- Address 2
- Alien
  - Illegal
  - Legal
  - No
- City
- State
- ZIP
- Birth date
- Sex
  - M= Male
  - F= Female
- Suspect
  - Y= Yes
  - N= No
- Death date
- Social Security number

- Race
  - 1= White
  - 2= Black
  - 3= Asian
  - 4= Indian
  - 5= Hispanic
  - 6= Other
- Primary language
  - E= English
  - S= Spanish
- Facility code (590 Only)
- Family size
- County code (See *Special Information* for a complete listing)
- Case
- Caseworker
- Next RID number

CSHCS

Not applicable to buy-in

Recipient Eligibility

The Recipient Eligibility window displays a dropdown box (Standard or Replaced) and allows the user to access the eligibility programs, Eligibility dates, aid categories, or view the replaced Health Program Eligibility. The fields include the following:

- RID number
- Name
- Health program
  - 59= 590 Program
  - AR= ARCH
  - K2= Hoosier Healthwise Package C
  - MA= Medicaid
- Aid category (Complete list is included under *Special Information*)
- Effective date
- End date
- Stop reason

- Death
- Regular
- Open

EOMB Request

Not applicable to buy-in

EPSDT

Not applicable to buy-in

ID Cards

Not applicable to buy-in

Lockin

Not applicable to buy-in

LOC

Not applicable to buy-in

Medicare

Displays a dropdown list box for Medicare. The dropdown list box gives allows the user to select one of the following options:

Billing A Mismatches

This window contains the transactions that do not match a recipient record in Indiana*AIM*. The fields required for a match are: HIB number, or RID number. The data includes:

- HIB
- Last name
- First name
- Middle initial
- Sex
- Birth date
- New HIB
- Process date

- Transaction
- Modifier
- Sub code
- Effective date
- IHCP ID
- Premium amount
- Apply to RID number

Billing B Mismatches

This window contains the transactions that do not match a recipient record in Indiana*AIM*. The fields required for a match are: HIB number or RID number. The data includes:

- HIB
- Last name
- First name
- Middle initial
- Sex
- Birth date
- New HIB
- Buy-In SSI
- Eligibility code
- Process date
- Transaction
- Modifier
- Subcode
- Effective date
- IHCP ID
- Premium amount

Apply to RID number

Buy-In Coverage

The Buy-In Coverage window is accessed though Options/Medicare while in any of the Medicare windows. This window shows Medicare buy-in data for Parts A and B and shows current and historical buy-in data. The window is primarily for information and is system generated

from the Buy-In Part A and B Billing Tapes according to the transaction codes used. The data includes:

- RID number
- Name
- HIB number
- Buy-In A effective date
- Buy-In A end date
- Total premium paid (Part A)
- Buy-In B effective date
- Buy-In B end date
- Total premium paid (Part B)
- Total Buy-In A premium paid
- Total Buy-In B premium paid
- Next RID number

Buy-In Billing Transactions Codes

This window contains the buy-in billing transaction codes that HCFA sends to the State through the monthly Buy-In Billing Tapes. To access this data, the user clicks on the transaction code on the Billing window or Premium window.

- Buy-In transaction
- Buy-In modifier
- Description

Dual Aid Category Eligibility

This window is identifies recipients with dual Medicare aid category eligibility. This window applies to the SLMB and QMB categories when a recipient also has IHCP as MAA, MAD, MAC, and so forth. The data includes the following:

- RID number
- Name
- Aid category
- Effective date
- End date

Dual Aid Category Codes

This window gives a description of the aid category listed below.

- Aid category
- Description

> *Note: The only dual aid categories listed on this window are MA J, MA L, and MA LP.*

Medicare Coverage

The Medicare window shows Medicare coverage whether the recipient has free Medicare Part A coverage, self-pay Medicare Part B coverage or Medicare Part A and/or B coverage paid by the State (Medicare buy-in). The Medicare data entered on this window is also accessed by the TPL system for third party cost avoidance and recovery from Medicare. Basic data is populated to the TPL Base window for easy inquiry. The Recipient Medicare Coverage window is accessed through **Options** on the Recipient Base window. HIB number changes may be entered in the HIB History field. This updates all other windows that display the HIB number. The data includes:

- RID number
- Name
- HIB number
- Medicare A effective date
- Medicare A end date
- Carrier number (Part A)
- Medicare B effective date
- Medicare B end date
- Carrier number (Part B)

Override

Part A Billing

This window views and verifies all Medicare billing transactions that were sent from HCFA via the monthly Buy-In Billing tape. The data is accessed by recipient and includes:

- RID number
- Name
- Error
- More Buy-In A information*
- HIB number
- Subcode
- Process date
- Transaction
- Modifier
- Effective date
- Premium amount
- Next RID number

Part B Billing

This window views and verifies all Medicare billing transactions that were sent from HCFA via the monthly Buy-In Billing tape. The data is accessed by Medicare/Options and includes:

- RID number
- Name
- Error
- More Buy-In B information*
- HIB number
- SSI code
- Eligibility code
- Subcode
- Process date
- Transaction
- Modifier
- Effective date
- Premium amount
- Next RID number

Premium 150

This window views, adds, updates, or deletes recipient information sent to HCFA via the monthly Buy-In Part B Premium (sending) tape. The data is accessed by RID number via recipient and includes:

- RID number
- Name
- Source
- Premium 150 process date
- HIB number
- Eligibility code
- Transaction code
- Buy-In B effective date
- Next RID number

Buy-In Premium Transaction Codes

This window contains the buy-in premium transaction codes that are sent to HCFA on the monthly Buy-In Premium S15 and 150 Tapes. To access this data, the user clicks on the transaction code on the Billing window or Premium window.

- Buy-In transaction
- Description

Premium S15

This window views, adds, updates, or deletes recipient information sent to HCFA via the monthly Buy-In Part A Premium (sending) tape. The data is accessed by RID number via recipient and includes:

- RID number
- Name
- Source
- Premium S15 process date
- HIB number
- Transaction code
- Buy-In A effective date
- Next RID number

Premium S15 Exceptions

This report is generated after the monthly Part A Buy-In Billing tape is processed by Indiana*AIM*. Any discrepancies resulting from this data are listed in the Part A Exceptions listing.

- HIB number
- Last name
- First name
- Middle initial
- Sex
- Birth date
- Zip code
- Source
- Transaction
- Effective date
- IHCP ID

Premium 150 Exceptions

This report is generated after the monthly Part B Buy-In Billing tape is processed by Indiana*AIM*. Any discrepancies resulting from this data and Indiana*AIM* are included in the Part B Exception listing.

- HIB number
- Last name
- First name
- Middle initial
- Sex
- Birth date
- Zip code
- Source
- Transaction
- Effective date
- IHCP ID

Patient Liability

Not applicable to buy-in

Potential MC Recipient

Not applicable to buy-in

Previous

This option displays previous names of a recipient and is accessible through any recipient window by clicking **Previous** from the Options tool. The following data is included:

- Addresses
- Names
- Previous Program Control Number (PCN)

The PCNs window views previous PCNs for a recipient. The PCN was used prior to Indiana*AIM* implementation to identify a recipient. The number changed if a recipient changed aid category, county, or other specific data. Therefore, it was necessary to track previous PCNs and the applicable dates. With the implementation of RID numbers, the recipient is assigned the same RID number regardless of changes in eligibility, county, or aid category.

The previous PCNs window contains the following data:

- RID number
- Name
- Previous identification number (May be a RID number or PCN)
- Effective date
- End date

PMP Assignment

Not applicable to buy-in

Recipient Mother RID

Not applicable to buy-in

Redetermination Date

Not applicable to buy-in

Search

Allows the user to search for a particular Medicaid member.

Spenddown

The Spenddown window is used to view the recipient's periods of spenddown and the effective dates. The window is accessed through the Recipient Base window by clicking **Spenddown Option.** The data includes:

- RID number
- Recipient name
- Effective date
- End date

590 Search

Not applicable to buy-in

Suspended ICES Dupe

Not applicable to buy-in

Link History

Not applicable to buy-in

Mgd Care Rate Cell

Not applicable to buy-in

Newborn PMP History

Not applicable to buy-in

Section 5: Reports

Buy-In Part A Billing (Receiving) (*BIA-1001-M*)

This report is a paper copy of the monthly buy-in transaction data from HCFA, transmitted via NDM, to IFSSA. The report provides Indiana with the status of Medicare Part A Buy-In recipients using transaction codes and related data and is sorted in HIB sequence.

Buy-In Part A Premium S15 (Sending) (*BIA-1002-M*)

This report is a paper copy of the monthly Part A Buy-In transaction data from Indiana, transmitted via NDM, by IFSSA to HCFA. The report is sorted in HIB sequence.

Buy-In Part A Exception Error by HIB (*BIA-1003-M*)

This report, in HIB sequence, lists the transactions from the Part A Billing tape that were either not accepted by HCFA due to matching errors and/or require further research by EDS. This report is also available in order by error transactions and more acceptable when correcting the data.

Buy-In Part A Exception Error by Transaction Code (*BIA-1004-M*)

This report, in transaction code sequence, lists the transactions from the billing tape that were either not accepted by HCFA due to matching errors and/or require further research by EDS. This report is also available in order by error transactions and more acceptable when correcting the data.

Buy-In Part A Recipients without QMB Also or QMB Only (*BIA-1005-M*)

This report, in county code sequence, lists all Buy-In Part A recipients that are on Buy-In Part A and are not enrolled as QMB recipients.

Buy-In Part A Pending Transactions Awaiting Three Months Reply (*BIA-1006-M*)

This report, in HIB sequence, lists the Buy-In Part A Premium S15 entries that were sent to HCFA and have not had a response in three months.

Buy-In Part A Control Report (*BIA-1007-M*)

This report identifies the Medicare Part A premium amount billed to the State by HCFA for the current billing month. The report further breaks down the amount by category of assistance.

Buy-In Part A Qualified Disabled Working Individuals (*BIA-1008-M*)

This report is a listing from the Buy-In Part A Billing tape of those individuals accreted, deleted, or changed on the QDWI program within Buy-In Part A. These individuals are only eligible to have their premiums paid by Indiana.

Buy-In Part B Billing (Receiving) (*BIB-2001-M*)

This report is a paper copy of the monthly buy-in transaction data from HCFA, transmitted via NDM, to IFSSA. The report provides Indiana with the status of Medicare Part B buy-in recipients using transaction codes and related data and is sorted in HIB sequence.

Buy-In Part B Premium 150 (Sending) (*BIB-2002-M*)

This report is a paper copy of the monthly Part B Buy-In transaction data from Indiana, transmitted via NDM, by IFSSA to HCFA. The report is sorted in HIB sequence.

Buy-In Part B Exception Error by HIB (*BIB-2003-M*)

This report, in HIB sequence, lists the transactions from the Part B Billing tape that were either not accepted by HCFA due to matching errors and/or require further research by EDS.

Buy-In Part B Exception Error by Transaction Code (*BIB-2004-M*)

This report, in transaction code sequence, lists the transactions from the billing tape that were either not accepted by HCFA due to matching errors and/or require further research by EDS.

Buy-In Part B Specified Low Income Medicare Beneficiaries (SLMB) Billing Transactions (*BIB-2005-M*)

This report, in HIB sequence, lists all Buy-In Part B recipients that are on the SLMB Program within Medicare Part B Buy-In.

Buy-In Part B Pending Transactions Awaiting Three Months Reply (*BIB-2006-M*)

This report, in HIB sequence, lists the Buy-In Part B Premium 150 entries that were sent to HCFA and have not had a response.

Buy-In Part B Control Report (*BIB-2007-M*)

This report identifies the Medicare Part B premium amount billed to the State by HCFA for the current billing month. The report further breaks down the amount by category of assistance.

Possible Medicare Eligibles (*BUY-3001-M*)

This report, in SSN sequence, lists recipients who have had a paid crossover claim and do not have Medicare A or Medicare B on the Medicare Coverage window.

Attempted HIB Updates to Already Accreted Buy-In Recipients (*BUY-3002-W*)

This report lists all ongoing Buy-In Part A or B recipients that ICES has sent a HIB update to Indiana*AIM*. The exceptions are as follows:

- Marital status changed from aged married (B) to aged widow (D)
- Disabled widow age 50-59 (W) changed to aged widow age 60+ (D)
- RR employee spouse/annuitant (MA) changed to widow/widower (WA – annuitant) (WD RR employee)

The purpose of this report is to identify invalid HIB updates on ICES for verification.

Linked Buy-In Recipients (*BUY-3003-D0*)

This report lists all recipients with duplicate RID numbers. Currently, a recipient is issued a RID number that remains throughout his or her IHCP history; however, in the past a new RID number may have been issued in error if IHCP was stopped and they were accepted into the IHCP at a later date.

Section 6: Forms and Letters

Erroneous PW Accretion (BUY-9001-R)

This letter is sent to HCFA for reimbursement of monthly Medicare premiums for which HCFA has billed the State incorrectly, usually through the PW (1167) transaction code.

The letter should contain the following:

- Mention of the phase in the HCFA manual for resolving erroneous accretions
- What erroneous accretion action was received and when
- What the State is currently doing and any action taken
- What the State needs to do to correct the erroneous accretion

ERRONEOUS PW ACCRETION
A reply is requested

TO: HCFA, BPO, DBS
Third Party Billing
P.O. Box 11977
Baltimore, MD 21207-0977

DATE: **December 19, 2000**

FROM: Indiana Medicaid Buy-In Unit
P.O. Box 68761
Indianapolis, Indiana 46268-0761

BENEFICIARY INFORMATION:
Full Name: **Jeena Smith** Sex: **Female**

Claim Number (HIB): **235485701M / 236128789D2** Date of Birth: **1900/06/04**

State Welfare Number (RID):100430750000 **SSN: 123-48-5678**

Relevant Accretion Date(s):

Relevant Deletion Date(s):

In regulation rule of 482 it states "If the state determines that the PW accretion date is incorrect (earlier than date of Medicaid eligibility) or that the individual has not been Medicaid eligible since the effective date of the PW accretion, the State's complaint must be directed to the HCFA RO."

Mr. Bruce Miller,

The State of Indiana received a transaction code of 1167 charging the State $682.50 for retro Medicare premiums with the HIB of 123485678D2. The State of Indiana has no record of this recipient being eligible for the Indiana Medicaid program and therefore, also not eligible for the Medicare Buy-in program.
I have also contacted the Evansville Social Security office to advise them that this client does not have eligibility for the Indiana Medicaid program and to correct their files.

Please correct your files and refund the State of Indiana $682.50 for the incorrect 1167 accretion. I appreciate your assistance.

Sincerely,

Sharon Williams (317) 488-5196 – FAX (317) 488-5377
950 N Meridian St., Suite 1150
Indianapolis, IN 46204 - 4288

Figure 6.1 – Erroneous PW Accretion Letter

Death Reimbursement Letter (BUY-9002-R)

This letter is sent to HCFA to correct a date of death (DOD), or to re-accrete an individual who was by mistake listed as deceased either by HCFA, SSA, or the OMPP. This notification is also needed to obtain reimbursement for premiums paid for months in which the recipient was listed as deceased in error. This notification is also required to get an individual accreted to buy-in for a period prior to the correct DOD when files have an earlier DOD.

DEATH REIMBURSEMENT LETTER

TO: Health Care Finance Administration
Transactions Branch
P.O. Box 11977
Baltimore, Maryland 21207

DATE: _____

FROM: Indiana Medicaid Buy-In Unit
P.O. Box 68761
Indianapolis, Indiana 46268-0761

_____

BENEFICIARY INFORMATION:

Full Name: _____ Sex _____

Claim Number (HIB) _____ Date of Birth _____

State Welfare Number (RID) _____

Relevant Accretion Date(s) _____

Relevant Deletion Date(s)_____

_____

_____Code 1600 HCFA deletion due to reported death in SSA's claim system.

_____Code 29___ ___ HCFA rejection of State accretion due to a death deletion.

_____Code 1753 HCFA acknowledgment of Indiana (150) death deletion.

_____Attached is a statement corroborated with SSA that this individual is alive. Please re-accrete effective ____ / ____ / ____

_____Attached is a statement corroborated with SSA that the date of death is erroneous. Please adjust date of death effective from ____ / ____ / ____ to ____ / ____ / ____.

Comments: _____
_____
_____
_____

Figure 6.2 – Death Reimbursement Letter

Ongoing Accretion Reimbursement Letter (BUY-9003-R)

This letter is sent to HCFA for a credit of monthly Medicare premiums for which HCFA has billed the OMPP twice for the same recipient during the same period through accretion transaction codes on the Buy-In Billing tape exchange. The letter should contain the following:

- The current status for buy-in
- HIB(s) being paid by the OMPP
- The results of research (contacts with Social Security and the county)
- The action needed by the OMPP to correct the file

ERRONEOUS PW ACCRETION
A reply is requested

TO: HCFA, BPO, DBS
Third Party Billing
P.O. Box 11977
Baltimore, MD 21207-0977

DATE: **October 13, 2000**

FROM: Indiana Medicaid Buy-In Unit
P.O. Box 68761
Indianapolis, Indiana 46268-0761

BENEFICIARY INFORMATION:
Full Name: **John Smith** Sex: **Male**

Claim Number (HIB): **314383225C3** Date of Birth: **1900/06/04**

State Welfare Number (RID):100310875899 **SSN: 314-00-1234**

Relevant Accretion Date(s):

Relevant Deletion Date(s):

In regulation rule of 482 it states "If the state determines that the PW accretion date is incorrect (earlier than date of Medicaid eligibility) or that the individual has not been Medicaid eligible since the effective date of the PW accretion, the State's complaint must be directed to the HCFA RO."

The State of Indiana received a transaction code of 1172/1772 charging the State $1,528.50 for an undetermined period. The Welfare number was incorrect showing ID 102390184499 which belongs to his brother (Joe Smith). Please change your records to show John Smith ID welfare number to be 100310875899.

Also, the State of Indiana has been paying the Medicare premiums for John Smith since 1991/05/01; therefore the amount charge the State, $1, 528.50, is incorrect and should be refunded.

If you have any questions, please contact me at (317) 488-5196 and as always, we appreciate your assistance in these matters.

Sincerely,

Sharon Williams (317) 488-5196 – FAX (317) 488-5377
950 N Meridian St., Suite 1150
Indianapolis, IN 46204 - 4288

Figure 6.3 – Ongoing Accretion Reimbursement Letter

Ongoing Accretion Reimbursement Letter (BUY-9004-R)Replaced with (BUY-9001-R)

This letter is sent to HCFA for a credit of monthly Medicare premiums for which HCFA has billed the OMPP incorrectly through ongoing 41 accretion transaction codes on the Buy-In Billing Tape Exchange.

ONGOING ACCRETION REIMBURSEMENT LETTER

TO: Health Care Finance Administration
Transactions Branch
P.O. Box 11977
Baltimore, Maryland 21207

DATE: **December 22, 2000**

FROM: Indiana Medicaid Buy-In Unit
P.O. Box 68761
Indianapolis, Indiana 46268-0761

BENEFICIARY INFORMATION:

Full Name: «FirstName» «MiddleInt» «LastName» Sex: «Sex»

Claim Number (HIB): «HIBnumber» Date of Birth: «DOB»

State Welfare Number (RID): «RidNumber»

This individual is an ongoing 41 accretion, effective «Date1».

_____ Individual is paying the Part B premium and the State of Indiana (150) is also paying the monthly premium.

_____ Individual insists no refund has been received. Buy-In effective «Date2».

_____ Claim for Part B coverage was denied for service date «Date3».
State of Indiana (150) is paying the premium effective «Date4».

Comments:_____

_____

_____

_____

Figure 6.4 – Ongoing Accretion Reimbursement Letter

Buy-In TPQY Letter (BUY-9006-R)

The ICES SSA Bendex for the TPQY data is now accessed and this letter is no longer needed. This letter is sent to the local Social Security Administration office so that buy-in case information can be reviewed and properly corrected and the recipient data may be appropriately updated in Indiana*AIM*.

Section 7: Contract Monitoring

Introduction

This section provides compliance data for selected key Request for Proposal (RFP) requirements and shows the following areas:

- The exact text of the RFP requirement
- EDS' operational definition

MBC-12

Requirement MBC-12
Track and report to the State the number of Buy-In mismatches on a monthly basis. This information should also be presented over time to illustrate trends. The report must be accompanied by a qualitative and quantitive analysis performed by the Contractor.

Operational Definition

Operational definition being developed

MBC-24

Requirement MBC-24
Maintain a sufficient number of toll-free phone lines (for Indiana and the contiguous states) and qualified personnel to staff the phone lines and respond to Buy-In questions from recipients and caseworkers so that the following requirements are met: Ninety-five percent (95%) of all calls must be answered within four (4) rings. No more than five percent (5%) of incoming calls ring busy. Ninety-five percent (95%) of calls that are answered must be answered by a live person with two (2) minutes. (Hold time must not exceed two (2) minutes. The average hold time must not exceed thirty (30) seconds. Call length is sufficient to ensure adequate information is imparted to the caller. The Contractor must obtain State Approval prior to limiting the number of topics that can be addressed by the caller.

Provide reports to monitor compliance with the above requirements.

Operational Definition

This section reports on measured phone statistics for the following:

1. Ninety-five percent of all calls are answered on or before the fourth ring. Due to phone system improvements implemented the second quarter of 1998, the telephone system is set up for only –zero to one ring. This item, therefore, warrants no special measurement since the phone system prevents this item from being out of compliance.
2. No more than five percent of incoming calls ring busy. Using the *High Level Phone Summary* report the total answered divided by the total calls provides this percentage.
3. Ninety-five percent of incoming calls are answered by Customer Assistance staff within two minutes (Hold time must not exceed two minutes). This measurement will come from the *CMS Split/Skill Call Profile* report adding all of the calls in the intervals 30, 60, 90, 120 seconds columns then dividing by the total calls.
4. The average hold time must not exceed 30 seconds. This measurement is derived from the average speed of answer found on both the *CMS Split/Skill Call Profile* or *CMS VDN* report.
5. Call length is sufficient to ensure adequate information is given to the caller. Using the *Split/Skill Call Summary* report this measurement is the ACD average talk time for the month.

MBC-25

Requirement MBC-25 Staff phone lines from 7:30 a.m. to 6:00 p.m., local time, Monday through Friday (excluding State holidays).

Operational Definition

Each week the TPL supervisor obtains a paper copy of the *Login/Logout* report for the Medicare toll-free lines for each of the five business days of the previous week. With OMPP's approva,l the phone lines are currently staffed from 7:30 a.m. to 4:30 p.m. In addition, the telephones are not staffed for one hour during the lunch period. Voice mail is activated so that callers may leave messages during the times telephones are not answered.

Section 8: Special Information

Aid Categories

Table 8.1 – Aid Categories

Definition	Acronym
Aged Indiana Health Coverage Programs	MA A
Blind Indiana Health Coverage Programs	MA B
AFDC Adult Indiana Health Coverage Programs	MA C
Disabled Indiana Health Coverage Programs	MA D
Extended Limited Indiana Health Coverage Programs For Pregnant Women	MA E
Transitional Medical Assistance (TMA)	MA F
Qualified Disabled Worker (QDW)	MA G
AFDC Indiana Health Coverage Programs For Deemed Income	MA H
Qualified Individual—1	MA I
Specified Low Income Medicare Beneficiary (SLMB)	MA J
Qualified Individual—2	MA K
Qualified Medicare Beneficiary (QMB)	MA L
Full-Range Indiana Health Coverage Programs For Pregnant Women	MA M
Limited Indiana Health Coverage Programs For Pregnant Women	MA N
AFDC For Institutional Child	MA O
Indiana Health Coverage Programs For Pregnant Recipients No Longer Fully Eligible Due To Increased Income, Limited	MA P
Refugee Medical Assistance (RMA)	MA Q
RBA Indiana Health Coverage Programs	MA R
AFDC Adult Indiana Health Coverage Programs For Sibling Income	MA S
AFDC Indiana Health Coverage Programs For Children 18-20	MA T
AFDC Indiana Health Coverage Programs For SSI Recipient	MA U
Indiana Health Coverage Programs For Newborns	MA X
Indiana Health Coverage Programs For Children Under 1	MA Y

(Continued)

Table 8.1 – Aid Categories

Definition	Acronym
Indiana Health Coverage Programs For Children Under 6	MA Z
Indiana Health Coverage Programs For Children Under 19	MA 1
Indiana Health Coverage Programs For Children 6-19	MA 2
Indiana Health Coverage Programs For WARDS	MA 3
Indiana Health Coverage Programs For IV-E Foster Children	MA 4
Indiana Health Coverage Programs For IV-E Adoption	MA 8
Children age 1-19 up to 150 percent poverty (CHIP1)	MA 9
Aged Refugee	MA AP
Blind Refugee	MA BP
AFDC Refugee	MA CP
Disabled Refugee	MA DP
Transitional Medical Assistance Refugee	MA FP
QDW Refugee	MA GP
AFDC Refugee	MA HP
QMB Refugee	MA LP
Full Range For Refugee Pregnant Women	MA MP
Limited Range, Refugee Pregnant Women	MA NP
AFDC For Refugee Institutional Child	MA OP
MA P For Refugee	MA PP
RBA Refugee	MA RP
MA S Refugee	MA SP
MA T Refugee	MA TP
MA U Refugee	MA UP
Newborns Refugee Children Under 1	MA XP
Refugee	MA YP
Children Under 6 Refugee	MA ZP
Children Under 19 Refugee	MA 1P
Children 6-19 Refugee	MA 2P
Wards Refugee	MA 3P
Indiana Health Coverage Programs For Refugee Foster Children	MA 4P
Indiana Health Coverage Programs For Adoption Refugee	MA 8P

County Division of Family and Children Directory

The directory of County Division of Family and Children offices is located at *www.state.in.us/fssa/HTML/DIRECTORY/dfc.html*.

Buy-In Schedule

1. 10th - 15th of the Month:

   IFSSA receives the buy-in billing data NDM from HCFA. An FTP transmit is created by IFSSA for Part A and a second tape for Part B and sent by EDS courier to EDS. If the tapes are created by 1 p.m., the tapes will be sent to EDS the same day. If the tapes are received after 1 p.m., they are sent to EDS the following morning.

2. Once received, the tapes are logged by EDS Systems. Next, the systems engineer assigned to perform buy-in runs the buy-in billing jobs within 24 hours of the tapes receipt from IFSSA. The following reports are produced:

Table 8.2 - Reports

Part A	Part B
BIA-1001-M	BIB-2001-M
BIA-1003-M	BIB-2003-M
BIA-1004-M	BIB-2004-M
BIA-1005-M	BIB-2005-M
BIA-1006-M	BIB-2006-M
BIA-1008-M	

The reports are delivered to IFSSA within five business days of the date the jobs are run in Indiana*AIM*.

3. The Billing FTP Transmit tapes are copied and archived by EDS and the originals are returned to IFSSA within seven business days.
4. The billing reports are researched, cases are worked and premium data is entered by EDS, as appropriate.
5. On the 21st of the month:

   The systems engineer assigned to perform buy-in runs the buy-in premium jobs. The following reports are produced:

Table 8.3 - Reports

Part A	Part B
BIA-1002-M	BIB-2002-M
BIA-1007-M	BIB-2007-M

The reports are delivered to IFSSA within five business days of the date the jobs are run in Indiana*AIM*.

6. The following day, the premium tapes are sent by EDS courier to IFSSA. IFSSA transmits the premium data to HCFA via NDM.
7. The Premium FTP Transmit are copied and archived by EDS and the originals are returned to IFSSA within seven business days.

Other Buy-In Reports Produced :

- **BUY-3001-M:** Due to IFSSA within five business days from the end of the month

- **BUY-3002-W:** Due to IFSSA within three business days from the end of the week

Buy-In and BENDEX Acronyms

Table 8.4 – Buy-In and BENDEX Acronyms

Acronym	Definition
AFDC	Aid to Families with Dependent Children
AIM	Advanced Information Management – (for example, Indiana*AIM*)
BENDEX	Beneficiary and Earnings Data Exchange
BEST	Health Insurance Beneficiary State Tape
BIC	Beneficiary Identification Code
CAC	Buy-In Category of Assistance Codes
CAN	Social Security Administration abbreviation for claim number
CASF	Carrier Alphabetic State File (Microfiche)
CDFC	County Division of Family and Children
CDPW	County Department of Public Welfare
CWF	Common Working File
DHHS	Department of Health and Human Services
EDB	Eligibility Data Base (also known as the HI Master)
EDP	Electronic Data Processing
EDS	Electronic Data Systems
ESRD	End-stage Renal Disease
FFP	Federal Financial Participation
FIS	Family Independence Section
FMAP	Federal Medical Assistance Percentage
FRCS	Federal Reserve Communication System (or Fedwire System)
GPABS	Group Premium Audit and Billing Section
HCFA	Health Care Finance Administration
HCFA RO	Health Care Finance Administration Regional Office
HI	Hospital Insurance - Medicare Part A
HOC	Hospital Insurance Option Code
HPAC	Hospital Insurance (HI) Premium Amount Collectable
ICES	Indiana Client Eligibility System
IEP	Initial Enrollment Period

(Continued)

Table 8.4 – Buy-In and BENDEX Acronyms

Acronym	Definition
IFSSA	Indiana Family and Social Services Agency
LAC	Living Arrangement Code
MA	Medical Assistance only
MBR	Monthly Benefit Payable - also, Master Beneficiary Record
MPS	Monthly Payment Center
MQFE	Medicare Qualified Federal Employees
MTS	Medicare Transaction System
NDM	Network Data Mover
PMTT	Programmable Magnetic Tape Terminal
POMS	Program Operations Manual System
PW	Social Security Administration Public Welfare (PW) Accretions
QDWI	Qualified Disabled Working Individual
QMB	Qualified Medicare Beneficiary
RRB	Railroad Retirement Board
RSDI	Social Security Administration Retirement Survivors and Disability Insurance
SEBSB	State Eligibility and Buy-In System Branch
SDPW	State Department of Public Welfare
SDX	Supplementary Security Income (SSI) State Data Exchange System
SGA	Substantial Gainful Activity
SISC	Supplemental Security Income Status Code
SLMB	Specified Low Income Medicare Beneficiary
SMI	Supplemental Medical Insurance – Medicare Part B (Buy-In)
SMIB	Supplemental Medical Insurance Option Code
SPAC	Supplemental Medical Insurance (SMI) Premium Amount Collectable
SSA	Social Security Administration
SSA CO	Social Security Administration County Office
SSA DO	Social Security Administration District Office
SSA RO	Social Security Administration Regional Office
SSI	Supplemental Security Income
SSIR	Supplemental Security Income Record
SSN	Social Security Number
SSO	Social Security Office

(Continued)

Table 8.4 – Buy-In and BENDEX Acronyms

Acronym	Definition
TPM	Third Party Master
TPFAB	Third Party Fiche Agency Bills – Monthly Billing File
TPQY	Third Party Query
TPTAB	Third Party Tape Agency Bills – Monthly Billing File
VA	Veterans Administration
XIX	Title Nineteen Indiana Health Coverage Programs

Alert Codes

Alert states have accretion responsibility for all coverage groups specified in the buy-in agreement. To assist alert states in identifying SSI recipients who are eligible for Medicare, HCFA provides alert codes to the State on a monthly basis.

The accretion codes listed below are for use by any state. A brief explanation is provided.

- Code 41—Ongoing accretion
- Code 61—Normal accretion initiation action
- Code 62—Special accretion action by the State after verification of Medicare entitlement by the SSA district office
- Code 63—Identical to code 61 but available for use by the OMPP for special accretion actions or for monitoring specific coverage groups
- Code 64—An optional accretion code used only by an auto-accrete state to accrete an SSI recipient who was not accreted through the automated SSA/HCFA data exchange
- Code 84—Designed for alert states to use when accreting individuals who are SSI recipients for whom the state received the code 86 alert record

Codes to Establish a Closed Period of Buy-In Coverage

- Code 75—The accretion action to establish the start date
- Code 76—The deletion action to establish the stop date

Codes for Deletion

- Code 16—Informs the State that the beneficiary is deceased.
- Code 50—Special deletion action used only to delete a code 1165 HCFA accretion action.
- Code 51—Normal deletion for an individual who is no longer a member of the State's coverage group.
- Code 53—A death deletion.

The State may change the following personal characteristics on the buy-in master record:

- Sex code
- Buy-in eligibility code
- State welfare identification number

- A code 99 can be used to add or change a buy-in eligibility code.

Acknowledgement codes for State initiated accretions and deletions (input codes 61, 62, 63, 64, 84) are listed below. They inform the State that the accretion has been completed.

- 11XX—Beneficiary has been accreted to State buy-in (code 11 is always followed by a two digit explanatory code)
- 1125—Accretion adjusted to a later date (a closed period of coverage which overlaps the accretion date, is on record for the State submitting the accretion)
- 1128—Accretion adjusted to a later date (a closed period of coverage which overlaps the accretion date, is on record for a different State)
- 4368—Accretion adjusted to an earlier date resulting in a debit to the State

Reject codes for state-initiated accretions (input codes 61, 62, 63, 64, 84) are listed in the following text.

- 18XX—Beneficiary does not have Medicare entitlement; however, the SSO is developing a claim for Medicare that may result in a code 1167 or 1180 accretion within the next several months
- 19XX—Beneficiary's application for Medicare was denied
- 21XX—(subcode) Accretion failed to match the EDB

- 22XX—Beneficiary does not have Medicare entitlement; however, the beneficiary is receiving Social Security disability benefits and may be entitled to Medicare at a future date.
- 24XX—The effective date is invalid.
- 25XX—(subcode) Accretion duplicates an existing master record
- 27XX—The accretion contained an impossible code.
- 29XX—(subcode) There is a death deletion on the TPM that conflicts with the accretion.
- 31XX—The accretion encountered a cross-reference action on the TPM and must be swung to the new location or, the TPS encountered an inactive master record which must be retrieved before the current transaction can be processed.
- 32XX—The coverage requested in the accretion is prior to existing coverage in the current history field on the TPM.
- 33XX—The beneficiary is on the TPM as a code 91 (SSI) for another state.
- 3662—(applies only to State input code 62) The accretion did not match the EDB.
- 20XX—There is no record of buy-in coverage under the claim number submitted or there is a record but jurisdiction rests with another state.
- 24XX—The effective date is invalid.
- 25XX—(subcode) Duplicates an existing master record
- 2750—(applies only to State deletion code 50) The deletion was not submitted within the proper timeframe, or the accretion action which the State is attempting to delete did not result from a code 1165.
- 34XX—The deletion code is incorrect, the beneficiary is on the TPM as a code 91 (SSI) for the state that submitted the deletion.
- 42XX—Represents a premium liability of credit adjustment to the State

Glossary

This glossary defines the universal terms of the Indiana Title XIX program as presented in the Request for Proposals (RFP). The spelling and capitalization is approved by the Office of Medicaid Policy and Planning (OMPP) for use in all documents.

590 Program — A state of Indiana medical assistance program for institutionalized persons under the jurisdiction of the Department of Corrections, Division of Mental Health, and Department of Health.

ARCH — Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.

AVR — Automated voice-response system used by providers to verify recipient eligibility by phone.

AWP — Average wholesale price used for drug pricing.

auto assignment — Indiana*AIM* process that automatically assigns a managed care recipient to a managed care provider if the recipient does not select a provider within a specified time frame.

BENDEX — Beneficiary Data Exchange. A file containing data from HCFA regarding persons receiving Medicaid benefits from the Social Security Administration.

bill — Refers to a bill for medical services, the submitted claim document, or the electronic media claims (EMC) record. A bill may request payment for one or more performed services.

buy-in — A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible medical assistance recipients, enrolling them in Medicare Part A or Part B or both programs.

CCF — Claim correction form. A CCF is generated by Indiana*AIM* and sent to the provider who submitted the claim. The CCF requests that the provider correct selected information and return the CCF with the additional or corrected information.

CCN — Cash control number. A financial control number assigned to identify individual transactions.

CFR — Code of Federal Regulations. Federal regulations that implement and define federal Medicaid law and regulations.

claim	A provider's request for reimbursement of Medicaid-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: HCFA-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.
contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
contractor, contractors, or the contractor	Refers to all successful bidders for the services defined in any contract.
core contractor	The successful bidder on *Service Package #1: Claims Processing and Related Services*.
core services	Refers to *Service Package #1: Claims Processing and Related Services*.
county office	County offices of the Division of Family and Children. Offices responsible for determining eligibility for Medicaid using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by HCFA and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible Medicaid recipients.
CPAS	Claims Processing Assessment System. An automated claims analysis tool used by the State for contractor quality control reviews.
CRF/DD	Community Residential Facility for the Developmentally Disabled.
CSHCS	Children's Special Health Care Services. A State-funded program providing assistance to children with chronic health problems. CSHCS recipients do not have to be Medicaid-eligible. If they are also eligible for Medicaid, children can be enrolled in both programs.
CSR	Customer service request.

customer	Individuals or entities that receive services or interact with the contractor supporting the Medicaid program, including State staff, recipients, and Medicaid providers (managed care PMPs, managed care organizations, and waiver providers).
designee	A duly authorized representative of a person holding a superior position.
DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through the Health Care Financing Administration.
DME	Durable medical equipment. Examples: wheelchairs, hospital beds, and other non-disposable, medically necessary equipment.
DPOC	Data Processing Oversight Commission. Indiana state agency that oversees agency compliance with all OMPP data processing statutes, policies, and procedures.
DRG	Diagnosis-related grouping. Used as the basis for reimbursement of inpatient hospital services.
DSH	Disproportionate share hospital. A category defined by the OMPP identifying hospitals that serve a disproportionately higher number of indigent patients.
DSS	Decision Support System. A data extraction tool used to evaluate Medicaid data, trends, and so forth, for the purpose of making programmatic decisions.
DUR	Drug Utilization Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.
EAC	Estimated acquisition cost of drugs. Federal pricing requirements for drugs.
ECC	Electronic claims capture. Refers to the direct transmission of electronic claims over phones lines to Indiana*AIM*. ECC uses point-of-sale devices and PCs for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
ECS	Electronic claims submittal. Claims submitted in electronic format rather than paper. See ***ECC, EMC***.

EDP	Electronic data processing
EFT	Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the OMPP directly to the provider's account.
EMC	Electronic media claims. Claims submitted in electronic format rather than paper. See ***ECC, ECS***.
EOB	Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's remittance advice.
EOMB	Explanation of Medicare benefits. A form provided by Indiana*AIM* and sent to recipients. The EOMB details the payment or denial of claims submitted by providers for services provided to recipients.
EOP	Explanation of payment. Describes the reimbursement activity on the provider's remittance advice (RA).
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for Medicaid-eligible recipients under the age of 21 offering free preventive health care services, such as: screenings, well-child visits, and immunizations. If medical problems are discovered, the recipient is referred for further treatment.
EVS	Eligibility Verification System. A system used by providers to verify recipient eligibility using a point-of-sale device, on-line PC access, or an automated voice response system.
FEIN	Federal employer identification number. A number assigned to businesses by the federal government.
FFP	Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.
FIPS	Federal information processing standards.
fiscal year - Indiana	July 1 - June 30.
fiscal year - federal	October 1 - September 30.
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single state agency responsible for administering the Indiana Medicaid program.

HCBS	Home- and Community-Based Services waiver programs. A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged recipients to allow them to live in the community and avoid being placed in an institution.
HCFA	Health Care Financing Administration. The federal agency in the Department of Health and Human Services that oversees the Medicaid and Medicare programs.
HCFA-1500	HCFA-approved standardized claim form used to bill professional services.
HCI	Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.
HCPCS	HCFA Common Procedure Coding System. A uniform health care procedural coding system approved for use by HCFA. HCPCS includes all subsequent editions and revisions.
HealthWatch	Indiana's preventive care program for Medicaid recipients under 21 years of age. Also known as EPSDT.
HIC	Health insurance carrier number.
HIO	Health insuring organization.
HMO	Health maintenance organization.
Hoosier Healthwise	Indiana Medicaid managed-care program. Hoosier Healthwise has three components including Primary Care Case Management (PCCM), Risk-Based Managed Care (RBMC), and Managed Care for Persons with Disabilities (MCPD).
HRI	Health-related items.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.
ICES	Indiana Client Eligibility System. Caseworkers in the county offices of the Division of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).

ICF/MR	Intermediate care facility for the mentally retarded. An ICF/MR provides residential care treatment for Medicaid-eligible, mentally retarded individuals.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IMD	Institutions for mental disease.
Indiana*AIM*	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.
ISMA	Indiana State Medical Association.
ITF	Integrated test facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job control language
LAN	Local area network
LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
lock-in	Restriction of a recipient to particular providers, determined as necessary by the OMPP.
LTC	Long-term care. Used to describe facilities that supply long-term residential care to recipients.
MAC	Maximum allowable charge for drugs as specified by the federal government.
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.

MCO	Managed care organization.
MCPD	Managed Care for Persons with Disabilities is one of three delivery systems in the Hoosier Healthwise managed care program. In MCPD, a managed care organization is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the Indiana Medicaid definition.
MEQC	Medicaid eligibility quality control.
MMIS	Medicaid Management Information System. Indiana's current MMIS is referred to as Indiana*AIM*.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
medical policy contractor	Successful bidder on *Service Package #2: Medical Policy and Review Services.*
NCPDP	National Council for Prescription Drug Programs.
NDC	National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.
NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to on-line, real-time eligibility information.
non-core services	Refers to *Service Packages #2 and #3.*
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.
NPIN	National provider identification number
OMNI	A point-of-sale device used by providers to scan recipient ID cards to determine eligibility.
OMPP	Office of Medicaid Policy and Planning

PA	Prior authorization. Some designated Medicaid services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.
PCCM	Primary care case management. One of three delivery systems within the Hoosier Healthwise managed care program. Providers in PCCM are reimbursed on a fee-for-service basis. Recipients are assigned to a primary medical provider (PMP) or group that is responsible for managing the care of the recipient and providing all primary care and authorizing specialty care for the recipient—24 hours a day, seven days a week.
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to Medicaid recipients assigned to the PMP's care.
POS	Place of service or point of sale, depending on the context
PPO	Preferred provider organization
PRO	Peer review organization
Pro-DUR	Prospective Drug Utilization Review. The federally mandated, Medicaid-specific prospective drug utilization review system and all related services and activities necessary to meet all federal Pro-DUR requirements and all DUR requirements.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.

RA	Remittance advice. A summary of payments produced by Indiana*AIM* explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
RBMC	Risk-based managed care. One of three delivery systems in the Hoosier Healthwise managed care program. In RBMC, a managed care organization is reimbursed on a per capita basis per month to manage the member's health care. The delivery system serves TANF recipients, pregnant women, and children.
RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
RFI	Request for Information.
RFP	Request for Proposals.
SDX	State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.
shadow claims	Reports of individual patient encounters with a managed care organization's (MCO's) health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.
SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
SPR	System performance review
SSA	Social Security Administration of the federal government
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
specialty vendors	Provide support to Medicaid business functions but the vendors are not currently Medicaid fiscal agents.
State	Spelled as shown, State refers to the State of Indiana and any of its departments or agencies.

subcontractor	Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.
SUR	Surveillance and Utilization Review. Refers to system functions and activities mandated by the Health Care Financing Administration (HCFA) that are necessary to maintain complete and continuous compliance with HCFA regulatory requirements for SUR including the following SPR requirements: 1. statistical analysis 2. exception processing 3. provider and recipient profiles 4. retrospective detection of claims processing edit/audit failures/errors 5. retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards 6. retrospective detection of fraud and abuse by providers or recipients 7. sophisticated data and claim analysis including sampling and reporting 8. general access and processing features 9. general reports and output
systems analyst/engineer	Responsible for performing the following activities: 10. Detailed system/program design 11. System/program development 12. Maintenance and modification analysis/resolution 13. User needs analysis 14. User training support 15. Development of personal Medicaid program knowledge
TANF	Temporary Assistance for Needy Families. A replacement program for Aid to Families with Dependent Children.
TPL	Third Party Liability.
TPL/Drug Rebate Services	Refers to *Service Package #3: Third-Party Liability and Drug Rebate Services.*

UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and customary charge.
UPC	Universal product code. Codes contained on the first data bank tape update and/or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
VFC	Vaccines for Children program.
WAN	Wide area network.
WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women, and to infants and children under 5 years of age.

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